

EXHIBIT 255A

**MODEL LETTER NOTIFICATION OF PENDING INVOLUNTARY
TERMINATION BASED ON CHOW REVIEW OF THE MEDICARE GENERAL
ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION
(FORM CMS-855)**

(Date)

Provider Name
Address
City, State, ZIP Code

Dear **(Provider Name)**:

Re: Provider Number **(Provider Number)**

Under the provisions of section 1866(b)(2)(A) and (C) of the Social Security Act (42 CFR 489.53) the Centers for Medicare & Medicaid Service (CMS) may terminate an agreement with a provider of services if it is determined that the provider: is not complying with the terms of the agreement or the provisions of title XVIII and regulations; fails to furnish information that CMS finds necessary for a determination as to whether payments are or were due under Medicare and the amounts due; refuses to permit examination of its fiscal or other records by, or on behalf of CMS, as necessary for verification of information furnished as a basis for claiming payment under Medicare; or fails to furnish ownership information.

The CMS has examined your application for a change of ownership, and after a careful review of the facts and circumstances has determined that under the new ownership, your facility does not meet the requirements for participation as a provider/supplier of services in the Medicare program for the following reason(s):

(Select applicable sentence.)

- **(Name (s) of excluded persons or organizations)** is/are currently excluded from participating in the Medicare program by the Office of the Inspector General.
- **(Name(s) of excluded persons or organizations)** is/are currently excluded from participating in the Medicare program because (he/she/it) is on the Federal Government's (General Service Administration) List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

(Name)

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(Date)

- You do not possess a current valid license that is required by Federal, State, or local government in order to furnish health care items or services of the type you purportedly furnish or intend to furnish to Medicare beneficiaries.
- You failed to furnish an address sufficient to readily identify the physical location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries; or having furnished such an address, you do not appear (on the basis of extrinsic evidence) to be furnishing items or services or otherwise operating from such location; or, if you are an individual practitioner who does not furnish or does not intend to furnish items or services to Medicare beneficiaries at or from a location controlled by you (e.g., a physician practicing exclusively as an employee), you failed to furnish an address sufficient to readily identify the physical location at which you can be personally served with required notice in the event that proves necessary.
- Your license, and any other information or documentation furnished by you with respect to such license, failed to show that such license was issued by a governmental entity having jurisdiction over a practice, service-delivery, or operating location designated by you as a location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries or that your license, if valid only for a specific physical location, is not valid for the physical location specified by you as the practice, service-delivery, or operating location at or from which you purportedly furnish or intend to furnish items or services to Medicare beneficiaries.
- Your (i) billing agreement, (ii) billing service contract, or (iii) other agreement that creates or maintains, directly or indirectly, a relationship between you and another entity for the purpose of billing, the sale or purchase or other transfer of accounts receivable, or other financial relationship effecting a transfer - directly or indirectly - of Medicare claims payment, or any other evidence, shows or furnishes substantial evidence that you are violating Medicare rules on assignment or reassignment of claims.

Based on the above information, action has been initiated to terminate coverage of (name of provider/supplier) in the Medicare program. You will receive a written notice informing you of the official date of termination. Please contact this office if you have taken steps to correct the violation.

(Name)

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(Date)

If you believe that this determination is incorrect, you may request that the decision be appealed. Your request must be submitted in writing to **(name and address of designated individual at RO)** within 60 days of this notice. Your request should state why you consider the determination to be incorrect and should be accompanied by any additional information or documentation that you feel may have a bearing on the determination. An Office of the Inspector General or Federal exclusion cannot be reconsidered; however, you may contest factual issues, such as exclusion status, if you feel the information is in error.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)